



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

REHAB ENGINEERING LAB
7703 FLOYD DURL DRIVE
SAN ANTONIO TX 78229

DWC Claim #:
Injured Employee:
Date of Injury:
Employer Name:
Insurance Carrier #:

Respondent Name

LUMBERMENS MUTUAL CASUALTY CO

Carrier's Austin Representative Box

Box Number 21

MFDR Tracking Number

M4-04-3466-01

MFDR Date Received

NOVEMBER 7, 2003

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary as Stated in the Table of Disputed Services: "We have received nothing."

Requestor's Supplemental Response dated November 25, 2003: "I am in receipt of correspondence dated 11/20/03 requesting additional documentation relating to TWCC Rule 133.307(g)(3). This letter and our original request are enclosed. There are no medical records as we are not physicians and the only documents relevant to the fee dispute are the statement and EOB's of denial from the payor. The billing form and our enclosed invoice gives a detailed description of each code; therefore, I am enclosing the description of the service for which payment is in dispute for your review. I fee [sic] confident upon your review the table of disputed services on codes will be paid. The reason for (c)(ii) as to why the disputed should be paid is obvious – we HAVE NOT ever been paid and are therefore due reimbursement for our services. I did resubmit this claim with correct HCPS codes from the 1996 Texas State Fee Schedule – which I had to purchase. None of our billed codes were in this Fee Schedule so I had to use base codes – L5999 with descriptions. I resent all of this information to the payor with a return receipt requested of which I enclosed a copy. As you can see my notes on one of the EOB's, I was told on 7/8/03 that it had not been received yet. If this was the case, then how could we be reimbursed for part of the claim (3 codes only) for \$6674.89. When I resubmitted the claim, there have been reason after reason as to why it could not be paid (see 11/27/02 correspondence). When the codes for pre-authorization were submitted, all of the L Codes were given with a description yet when I billed using the same codes for which I WAS given authorization, five codes were denied. As you can see from my notes on the EOB's, I have tried several times to contact the payor without success. The last several times I did not document dates as all I got was voice mail and my messages were not returned even when I reported that I was filing a complaint against them."

Amount in Dispute: \$35,755.12

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "...This is a fee dispute concerning date of service 8/6/02. All fees were paid according to MFG..."

Supplemental Response dated December 19, 2003: "Carrier has previously responded to this dispute on 12/02/2003. Carrier has allowed \$6,674.89 on this claim. Carrier maintains its position as outlined in the original response."

Response Submitted by: Flahive, Ogden & Latson, PO Drawer 13367, Austin, TX 78711

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 6, 2002	HCPSC Codes *L5321, L5324, L5631, L5649, L5650, L5828, L5920, L5950, L5964, L5979, L5999	\$35,755.12	\$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.1 provides for fair and reasonable reimbursement of health care in the absence of an applicable fee guideline.
3. Texas Labor Code §413.011 sets forth provisions regarding reimbursement policies and guidelines.
4. This request for medical fee dispute resolution was received by the Division on November 7, 2003. Pursuant to 28 Texas Administrative Code §133.307(g)(3), effective January 1, 2003, 27 *Texas Register* 12282, applicable to disputes filed on or after January 1, 2003, the Division notified the requestor on November 20, 2003 to send additional documentation relevant to the fee dispute as set forth in the rule.
5. The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of benefits dated June 3, 2003

- *00850 - LE

Findings

1. HCPSC Code L5321 is the correct code. The requestor has incorrectly listed L5320 on the table of disputed services. Review of the invoice and CMS-1500 indicates HCPSC Code L5321.
2. The insurance company did reimburse the requestor, \$6,674.89 for HCPSC codes L5845, L5930 and L5846. According to the table of disputed services these codes are not in dispute.
3. This dispute relates to services with reimbursement subject to the provisions of 28 Texas Administrative Code §134.1, effective May 16, 2002, 27 *Texas Register* 4047, which requires that "Reimbursement for services not identified in an established fee guideline shall be reimbursed at fair and reasonable rates as described in the Texas Workers' Compensation Act, §413.011 until such period that specific fee guidelines are established by the commission."
4. Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.
5. 28 Texas Administrative Code §133.307(g)(3)(B), effective January 1, 2003, 27 *Texas Register* 12282, applicable to disputes filed on or after January 1, 2003, requires the requestor to send additional documentation relevant to the fee dispute including "a copy of any pertinent medical records." Review of the submitted documentation finds that the requestor has not provided copies of all medical records pertinent to the services in dispute. The requestor responded to the Divisions request for additional information on November 25, 2003 stating, "There are no medical records as we are not physicians and the only documents relevant to the fee dispute are the statement and EOB's of denial from the payor." The Division concludes that the requestor has not met the requirements of §133.307(g)(3)(B).
6. 28 Texas Administrative Code §133.307(g)(3)(C)(iv), effective January 1, 2003, 27 *Texas Register* 12282, applicable to disputes filed on or after January 1, 2003, requires that the request shall include a position statement of the disputed issue(s) that shall include "how the submitted documentation supports the requestor position for each disputed fee issue." Review of the requestor's documentation finds that the requestor has not discussed how the submitted documentation supports the requestor position for each disputed fee issue. The Division concludes that the requestor has not met the requirements of §133.307(g)(3)(C)(iv).
7. 28 Texas Administrative Code §133.307(g)(3)(D), effective January 1, 2003, 27 *Texas Register* 12282, applicable to disputes filed on or after January 1, 2003, requires the requestor to provide "documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement." Review of the submitted documentation finds that:

- The requestor has not articulated a methodology under which fair and reasonable reimbursement should be calculated.
- Documentation of the amount of reimbursement received for these same or similar services was not presented for review.
- The requestor did not submit documentation to support that payment of the amount sought is a fair and reasonable rate of reimbursement for the services in this dispute.
- The requestor did not submit nationally recognized published studies or documentation of values assigned for services involving similar work and resource commitments to support the requested reimbursement.
- The requestor did not support that payment of the requested amount would satisfy the requirements of 28 Texas Administrative Code §134.1.

The request for additional reimbursement is not supported. Thorough review of the documentation submitted by the requestor finds that the requestor has not demonstrated or justified that payment of the amount sought would be a fair and reasonable rate of reimbursement for the services in dispute. Additional payment cannot be recommended.

Conclusion

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation does not support the reimbursement amount sought by the requestor. The Division concludes that this dispute was not filed in the form and manner prescribed under Division rules at 28 Texas Administrative Code §133.307. The Division further concludes that the requestor failed to support its position that additional reimbursement is due. As a result, the amount ordered is \$0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	January 11, 2013 Date
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YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision* together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party.****

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.